Phone: 480-575-0576 **Fax: 480-575-0512**
www.doctorcareaz.com

Assignment of Benefits

I understand by signing this form, I am authorizing the following:

1. Assignment of Medicare and/or Medicaid (Ahcccs) insurance benefits to Joel Cohen, MD, Medical Director of MD RoomService/DoctorCare, PLLC. (PO Box 7904, Cave Creek, AZ 85327)
2. Direct billing to Medicare and/or Medicaid (Ahcccs) – **electronically** or on paper claim forms.
3. Release of my medical information to Medicare and/or Medicaid (Ahcccs).
4. Dr. Joel Cohen may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.
5. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments and deductibles.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare and/or Medicaid (Ahcccs) to issue payment check(s) directly to Dr. Joel Cohen for medical services rendered to myself and/or my dependents. **I understand that I am responsible for any amount not covered by insurance**.

Authorization to Release Information
I hereby authorize Dr. Joel Cohen to: (1) Release any information necessary to insurance carriers regarding my illness and treatments; (2) Process insurance claims generated in the course of examination or treatment; and (3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Joel Cohen on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature: **Date:**

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